DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00 COMP		ETED
		155295	B. WIN			05/04/2	011
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				FREEMAN ST		
CLINITON	I UOLICE UEALTU	AND REHAB CENTER		1	FORT, IN46041		
CLINTO	THOUSE HEALITH	AND REHAB CENTER		FIXAIN	FORT, IN4004 I		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
	This visit was for	r a Post Survey Revisit	F0	000	This plan ofi correctfon is tfhe cen	tfer's	
	(PSR) to the Rec	ertification and State			credible allegatfon ofi compliance		
	l ` ′	y completed on 3/25/11.			Preparatfon and/or correctfon do		
	Licensure Survey	y completed on 3/23/11.			notf constftfutfe an admission by t	fhe	
		e je esalisa			provider ofi tfhe tfrutfh or tfhe fia	ctfs	
		conjunction with the			alleged or conclusion setf fiortfh in	n tfhe	
	Investigation of	Complaint numbers			stfatfementf ofi deficiencieThe pla	n	
	IN00089874, IN	00089459, and			ofi correctfons is prepared and /or		
	IN00089779.				excutfed solely because itf is requi	ired	
					by tfhe provisions ofi tfhe Stfatfe a	ınd	
	Common datas. M	[ 1 2 2 1 4 2011			Federal law.		
	Survey dates: M	fay 1, 2, 3, and 4, 2011			We are respectfully requestfng a		
					desk review ofi tfhe plan ofi correc	ctfon	
	Facility number:	000192			fior alleged deficiencies		
	Provider number	: 155295					
	AIM number: 10	00291120					
		00271120					
	C						
	Survey team:						
		W, TC (May 2 and 3,					
	2011)						
	Donna M. Smith	, RN (May 2, 3, and 4,					
	2011)						
	· /	N (May 2, 3, and 4, 2011)					
	DeAnn Mankell,	IXIN					
	Census bed type:						
	SNF/NF: 55						
	Total: 55						
	Census payor typ	ne.					
	Medicare: 5	,					
	Medicaid: 41						
	Other: 9						
	Total: 55						
							G10 D 15=
LABORATOR	Y DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESENTATIVE'S SI	JNATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

P42B12

Facility ID:

l	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155295	(X2) MULTIPLE CC  A. BUILDING  B. WING	00		E SURVEY PLETED 2011
	PROVIDER OR SUPPLIER	AND REHAB CENTER	809 W	ADDRESS, CITY, STATE, ZIP C FREEMAN ST FORT, IN46041	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	Sample: 10					
		es also reflect state rdance with 410 IAC 16.2.				
	Quality review of Cathy Emswiller					

PRINTED: 05/26/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION   155295   3. BUILDING   00   05/04/    NAME OF PROVIDER OR SUPPLIER  CLINTON HOUSE HEALTH AND REHAB CENTER   STREET ADDRESS, CITY, STATE, ZIP CODE   809 W FREEMAN ST   FRANKFORT, IN46041    (X4) ID   SUMMARY STATEMENT OF DEFICIENCIES   ID   PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG   REGULATORY OR LSC IDENTIFYING INFORMATION)   TAG   DEFICIENCY    FO157   SS=D   A facility must immediately inform the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to	SURVEY
NAME OF PROVIDER OR SUPPLIER  CLINTON HOUSE HEALTH AND REHAB CENTER  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F0157  SS=D  A facility must immediately inform the resident's physician; and if known, notify the resident's representative or an interested family member when there is an accident involving the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening	LETED
NAME OF PROVIDER OR SUPPLIER  CLINTON HOUSE HEALTH AND REHAB CENTER  (X4) ID PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  F0157  SS=D  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening	2011
CLINTON HOUSE HEALTH AND REHAB CENTER  (X4) ID PREFIX TAG  FRANKFORT, IN46041  FRANKFORT, IN46041  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  A facility must immediately inform the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening	
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F0157 A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening	COMPLETION
resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening	DATE
alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.  The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.  F0157  F157 It is the practice of this facility to promptly notify the residents physician and legal representative or interested family member of changes in condition and plan of care. 1.) Resident # L has been assessed by a Licensed Nurse to ensure there were no adverse effects from alleged	05/25/2011
deficient practice. II.) Residents	

PRINTED: 05/26/2011 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	A. BUILDING	00 	COMPI	LETED
		155295	B. WING		05/04/2	2011
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE		
CLINTON	N HOUSE HEALTH	AND REHAB CENTER		FREEMAN ST (FORT, IN46041		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG			DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	with physician orders for glucose monitoring have potential to be affected by alleged deficient practice review of residents current house medical record for days with blood glucose monitoring orders was concerned and the physician notified previously unreported blood glucose results meeting produced notification parar III.) Licensed nursing states been re-educated on facistandard of practice for "Notification of Change in Condition" and expectation notification of physician(structure) IV.) The Director of Nursidesignee will review blood glucose monitoring record for 4 weeks, then weekly weeks to ensure results in the physician's ordered parameters for notification reported to the physician Non-compliance will be addressed through 1:1 re-education and/or progulated in the production of the physician was also indicated and then quarterly with a subsequent plan develop implemented as indicated ADDENDUM: The Director of the production in the physician of the physician was also indicated and the physician and then quarterly with a subsequent plan develop implemented as indicated ADDENDUM: The Director of the production in the physician of the physician of the physician and then quarterly with a subsequent plan develop implemented as indicated and plant in the physician of the physi	blood the y the A htly in past 30 impleted d of any bod ohysician meters. iff have lity ons for c). ing or d ds daily a week for 4 meeting n are ressive cated. in QA&A nonths ed and d. ctor of	DATE
				Nursing or designee will a blood glucose monitoring		
				daily for 4 weeks, then 3	times a	
				week for 4 weeks, then w 4 weeks, and monthly tim		
				- weeks, and monthly till	IES J	

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU COMPLE	
AND FLAN	OF CORRECTION	155295		LDING	00	05/04/20	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				FREEMAN ST		
		AND REHAB CENTER		FRANK	FORT, IN46041		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
	Based on record	review and interview, the ensure the physician was			months to ensure results me the physician's ordered parameters for notification an reported to the physician.		
	notified as ordere	ed concerning a blood					
	sugar of less than	60 for 1 of 3 residents					
		od sugars/accuchecks in a					
	sample of 10.						
	(Resident #L)						
	Findings include	:					
	5/02/11 at 12:15 diagnoses include	p.m. The resident's ed, but were not limited Insulin dependent					
	notify the physic	der, dated 7/31/10, was to ian with an accucheck ult of < (less than) 60 or					
	check and record	der, dated 7/29/10, was to blood sugar twice daily. were scheduled for 6 a.m.					
	RECORD" indicates result on 4/30/11	'INSULIN FLOW ated the Blood Sugar at 6 a.m. was 47 with ion concerning the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI A. BUII		NSTRUCTION  00	COM	TE SURVEY MPLETED	
		155295	B. WIN	G		— 05/0 <sub>4</sub>	4/2011
	PROVIDER OR SUPPLIER	AND REHAB CENTER		809 W F	.DDRESS, CITY, STATE, ZIP C FREEMAN ST FORT, IN46041	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	notified concerni	tion if the physician was ng this blood sugar 0/11 at 6 p.m. accucheck					
		nation was indicated in ords concerning the ugars.					
	interview, the DO not determine on the "INSULIN FI nurse had called	:05 a.m. during an DN indicated she could 4/30/11 at 6:00 a.m. on LOW RECORD" if the the physician for a low ot, and she would check					
	today concerning 4/30/11. At this a provided the "CF CONDITION RE HYPOGLYCEM 4/30/11, which in	ON indicated the t been notified until the blood sugar of 47 on same time, the DON HANGE OF					
	3/25/11. The fac	ciency was cited on ility failed to implement of correction to prevent					

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155295	A. BUILDING B. WING		05/04/2011
	PROVIDER OR SUPPLIER	AND REHAB CENTER	809 W F	DDRESS, CITY, STATE, ZIP CODE FREEMAN ST FORT, IN46041	
				FORT, IN4004T	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
F0272 SS=D	standardized repro- each resident's fur A facility must make assessment of a re RAI specified by the must include at lead Identification and of Customary routine Cognitive patterns Communication; Vision; Mood and behavion Psychosocial well- Physical functioning Continence; Disease diagnosist Dental and nutrition Skin conditions; Activity pursuit; Medications; Special treatments Discharge potentian Documentation of regarding the additional performed through protocols; and Documentation of Based on record of facility failed to delive the support	prehensive, accurate, oducible assessment of national capacity.  As a comprehensive desident's needs, using the ne State. The assessment dest the following: demographic information;  The patterns; The assessment demographic information;  The patterns; The assessment demographic information;  The patterns; The patterns; The patterns; The assessment demographic information;  The patterns; The patterns; The patterns; The assessment demographic demographic information;  The patterns; The pat	F0272	F272 It is the practice of this facility to make a comprehen assessment of a residents no using the resident assessme instrument (RAI) specified by	eed, ent

STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DA			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155295	B. WIN			05/04/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R		1	FREEMAN ST		
CLINTO	N HOUSE HEALTH	AND REHAB CENTER		1	FORT, IN46041		
	THOUSE HEALTH	AND REHAB CENTER		LIVAININ	1 01(1, 11(4004)		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		nan 60 was obtained for 1			State, I.) Resident L has be		
	of 3 residents rev	viewed for blood			assessed by a Licensed Nu ensure there were no advers		
	sugars/accuchec	ks in a sample of 10.			effects from alleged deficien		
	(Resident #L)				practice, and physician has		
					notified of any change in co		
	Findings include	•			II.) Residents with diagnosis	s of	
	Findings include.				diabetes who experience		
	1 The UDEACT	CIONE TO INCLUDE OF			hypo/hyperglycemic reaction		
		TIONS TO INSULIN OR			have the potential to be affe		
	ORAL AGENTS" (revised 06/01/2010)				by this alleged deficient prac A review of residents curren		
	policy was provided by the Nursing				house with diagnosis of diak		
	Consultant on 5/03/11 at 3:55 p.m. This				medical record for last 30 da		
	current policy indicated the following:				was completed and the phys		
					has been notified if any cha	nge in	
	"Purpose: The p	ourpose of this procedule			condition has occurred. III.)		
	1 ^ ^	sh guidelines for			Licensed Nurses were		
	hypoglycemic re	_			re-educated regarding the fa "Change of Condition" stand		
	in posity connected	actions.			practice including assessme		
	Due ee deene				the resident and notification		
	Procedure	60 : 64			physician for change in resid		
	· ·	60, give one of the			condition. IV.) The Director		
	following:				Nursing or designee will mo		
	120 cc (cubic ce	ntimeters) Orange Juice			resident's medical record fo	r	
	to non-renal pati	ent			changes in condition and		
					completion of resident assessments 3 times a wee	k for	
	4) Repeat acci	ucheck in 15 minutes. If			4 weeks, then weekly for 4	IOI	
	results are still <	(less than) 60, repeat			weeks, then monthly therea	fter.	
	#3"	, , ,			Non-compliance will be		
					addressed through 1:1		
	2 Resident #I !a	record was reviewed on			re-education and/or progres		
					disciplinary actions as indica		
		p.m. The resident's			Results will be reviewed in ( meeting monthly for 3 month		
		led, but were not limited			and then quarterly with a		
		Insulin dependent			subsequent plan developed	and	
	diabetic mellitus	L.			implemented as		
					indicated.ADDENDUM:The		
	The physician or	rder, dated 7/31/10, was to			Director of Nursing or design	nee	

NAME OF PROVIDER OR SUPPLIER  CLINTON HOUSE HEALTH AND REHAB CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  A. BUILDING B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 809 W FREEMAN ST FRANKFORT, IN46041  (X5) PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE)			X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU	
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NAME OF PROVIDER OR SUPPLIER  CLINTON HOUSE HEALTH AND REHAB CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  809 W FREEMAN ST FRANKFORT, IN46041  (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  COMPLETION DATE			100290	B. WIN			05/04/20	
CLINTON HOUSE HEALTH AND REHAB CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  FRANKFORT, IN46041  ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  COMPLETION DATE	NAME OF I	PROVIDER OR SUPPLIER			1			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH OFFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE	CLINITO	N HOUSE HEALTH	AND DEHAR CENTED		1			
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG DEFICIENCY  COMPLETION DATE						. 01(1, 11(40041		
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE								
		· ·				CROSS-REFERENCED TO THE APPROPRIA	TE '	
E HOUTY THE DRYSICIAN WITH AN ACCHONOCK TO THE WILL HOUTING TESTUCITY STREETING TO		ŧ	· · · · · · · · · · · · · · · · · · ·		_	will monitor resident's medic	al	
result of less than 60 or greater 350 record for changes in condition		1 , , ,				_	tion	
and completion of resident			1 00 01 <b>B</b> 1 <b>0000</b> 1 200.				1	
On 5/03/11 at 10:05 a.m. during an assessments 3 times a week for 4 weeks, then weekly for 4		On 5/03/11 at 10	:05 a.m. during an				K IOI	
interview, the DON indicated she could weeks, then monthly times 4			<del>-</del>			_		
not determine on 4/30/11 at 6:00 a.m. on months to ensure compliance.		· ·				months to ensure complianc	e.	
the "INSULIN FLOW RECORD" if the								
nurse had called the physician for a low		nurse had called	the physician for a low					
blood sugar or not, and she would check		blood sugar or no	ot, and she would check					
on it.		on it.						
On 5/03/11 at 2:20 p.m. during an		On 5/03/11 at 2:2	20 p.m. during an					
interview, the DON indicated the		interview, the DO	ON indicated the					
physician had not been notified until		physician had no	t been notified until					
today concerning the blood sugar of 47 on		today concerning	the blood sugar of 47 on					
4/30/11. At this same time, the DON		4/30/11. At this	same time, the DON					
provided the "CHANGE OF		provided the "CF	IANGE OF					
CONDITION REPORT -								
HYPOGLYCEMIC EPISODE," dated			•					
4/30/11. This report indicated no recheck		1 ^						
of a blood sugar on 4/30/11 until 6:00		· ·						
p.m., which was 62. The resident's "Meal		1 -						
intake During this time-frame" was								
indicated from 50 % to 75%. No further								
information was indicated related to an								
assessment of the resident's condition								
during this low blood sugar reading on		_						
4/30/11 on this form.		4/30/11 on this fo	OHH.					
No further information was indicated		No further inform	nation was indicated					
concerning an assessment/evaluation of								
the 4/30/11 at 6 a.m. blood sugar in the		1						
resident's record.			_					
Testacités record.		105ideiit 5 iccold.						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE
F0282 SS=D	facility must be pro	-					
	Based on record facility failed to including insulin was readmitted to residents readmit sample of 13 (Refindings include 1. Resident G's diagnot limited to, ag fibrillation, hypermellitus, coronar gastroesophagear	d: closed clinical record was 11 at 10:34 A.M. gnoses included, but were citation, depression, atrial rtension, diabetes ry artery disease, and I reflux disease.  ned from the hospital on	F0	282	F282 It is the practice of this facility to provide qualified persons in accordance with a resident's written plan of care Resident G no longer resides this facility. II.) Residents with physician orders for medication and/or glucose monitoring has the potential to be affected by alleged deficient practice. A review of current in house residents' medication and treatment administration rechas been completed to identify any missing medications or treatments and physicians notified as applicable. Licens nurses have been re-educate facility expectations for administering medications, and performing blood glucose monitoring as ordered by the physician. The Director of Nursing or designee will revie blood glucose monitoring recommendations.	each e. I.) s in h on ave y this ords ify ed ed on	05/25/2011

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155295	- 1	LDING	00	05/04/2011
		100230	B. WIN		DDDDGG GITTY GTATE TIN CODE	00/04/2011
NAME OF P	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE FREEMAN ST	
CLINTON	N HOUSE HEALTH	AND REHAB CENTER		1	FORT, IN46041	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	Resident G's Apr	il 2011 MAR			medication and treatment	
	(medication adm	inistration record) for			administration records daily tweeks, then 3 times a week	l l
	4/15/2011 indica	ted Resident G's 4 P.M.			weeks, then weekly for 4 week	
	Accucheck was r	not completed.			to ensure glucose monitoring	
					medications are administere	
	Resident G's Apr	il 2011 MAR			ordered blood glucose monit	- 1
	(medication adm	inistration record) for			results meeting the physiciar ordered parameters for	15
	4/15/2011 indica	ted the following			notification are reported to the	e
	medications were	e not given:			physician. Non-compliance v	vill be
	"Remeron (antide	epressant) 15 mg			addressed through 1:1	since
	(milligrams). Giv	ve 1/2 tablet (7.5 mg.)			re-education and/or progress disciplinary actions as indica	
	orally daily at be	dtime."			Results will be reviewed in	
	"Lanoxin (streng	then and regulate heart			monthly QA&A meeting for	
	rate) 0.25mg. Giv	ve 1 tablet orally daily at			months and then quarterly w	
	bedtime only."				subsequent plan developed a implemented as indicated.	anu
	"Kepra (anti-seiz	ture medication) 500 mg			ADDENDUM: The Director o	f
	tablet. Give 1 tal	blet orally every 12.			Nursing or designee will revi	
	(Scheduled for 9)	:00 P.M."			blood glucose monitoring rec	cords,
	"Potassium ER 1	0 MEQ			medication and treatment administration records daily t	for 4
	(milliequivalents	) bid. (Scheduled for 5			weeks, then 3 times a week	
	P.M.)"				weeks, then weekly for 4 week	
					then monthly times 3 months	
	During an intervi	iew with the DON			ensure glucose monitoring a medications are administered	
	(director of nurse	es) on 5/4/11 at 10:50			ordered blood glucose monit	
	A.M., she indicat	ted she did not know why			results meeting the physiciar	
	the accucheck wa	as not done and the			ordered parameters for	
	medications not g	given.			notification are reported to the physician.	
	TTL: . C. 1 1 .					
	_	relates to complaint				
	IN00089779.					
	3.1-35(g)(2)					
	(6)(-)					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155295		(X2) M A. BUII B. WIN	LDING	NSTRUCTION  00	(X3) DATE : COMPL 05/04/2	ETED	
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
CLINTON	N HOUSE HEALTH	AND REHAB CENTER		1	FREEMAN ST FORT, IN46041		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
F0314 SS=D	a resident, the factoresident who enterpressure sores do sores unless the irredemonstrates that a resident having processary treatments.	prehensive assessment of lity must ensure that a rs the facility without es not develop pressure individual's clinical condition they were unavoidable; and pressure sores receives ent and services to promote ifection and prevent new ping.	FC	314	F314 It is the practice of this facility to ensure that a reside with a pressure sore have the necessary treatment and ser to promote healing, prevent infection and prevent new pressure sores. I.) Resident has been assessed to ensure adverse affects have been identified due to the alleged deficient practice. II.) Reside who are being treated for opearea have been assessed for adverse reaction and physici notified of any changes in condition. III.) Physical Themand Licensed Nurses have the re-educated on proper techn for performing clean dressing changes and timely implementation of intervention for prevention of skin breakd IV.) The Director of Staff Development or designee with observe one Physical Therapy/Licensed Nurse performance of clean dressing change weekly for 4 weeks, monthly for 2 months. The	e vices  J e no ents en r any an apy been ique J ons own.	05/25/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155295		(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 05/04/2011				
	ROVIDER OR SUPPLIER HOUSE HEALTH	AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  809 W FREEMAN ST FRANKFORT, IN46041					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	Based on observer interview, the factoristic change manner to prevent infections for 1 control whose dressing of failed to ensure primplemented times.	ations, record review, and cility failed to ensure a was completed in a ant the potential for of 1 resident (Resident #J) change was observed and preventive measures were ally to prevent further akdown for 1 of 1		Director of Nursing or design will review treatment administration records daily weeks, then 3 times a week weeks, then weekly for 4 were to ensure treatments are administered as ordered. Non-compliance will be addressed through 1:1 re-education and/or progress disciplinary actions as indicated as indicated. Results will be reviewed in monthly QA&A meeting for months and then quarterly weeksequent plan developed implemented as indicated. ADDENDUM: The Director Staff Development or design will observe one Physical Therapy/Licensed Nurse performance of clean dressic change weekly for 4 weeks, monthly for 5 months. The Director of Nursing or design will review treatment administration records daily weeks, then 3 times a week weeks, then weekly for 4 weeks, then monthly times 3 month ensure treatments are administered as ordered.	for 4 for 4 eeks  sive ated.  3 with a and of nee  ng then nee  for 4 for 4 eeks,			

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	INSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155295	A. BUI	LDING	00	COMPLETED 05/04/2011	
		100290	B. WIN			03/04/2011	
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE FREEMAN ST		
CLINTON	N HOUSE HEALTH	AND REHAB CENTER		1	FORT, IN46041		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		<b>(</b> 5)
PREFIX	` ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEF CHENCY)	DA	IE.
	sample of 10.	nt #L) observed in a					
	Sample of 10.						
	Findings include:						
	1. The "Hand Washing" policy was						
	provided by the Director Of Nursing						
	(DON) on 5/3/11 at 12:40 p.m. This						
	current policy indicated the following:						
	"PURPOSE						
	* Medical aseps	is to control infection.					
	* To reduce tran	smission of organisms					
	from resident to	resident.					
	* To reduce tran	smission of organisms					
	from nursing stat	ff to resident.					
	* To reduce tran	smission of organisms					
	from resident to	nursing staff.					
	PROCEDURE	*					
	7. Rub hands b	oriskly using sufficient					
	lather and friction	n for ten to fifteen					
	seconds,"						
	The "Dressing C	hange, Clean" policy was					
	_	DON on 5/03/11 at 12:40					
	-	t policy indicated the					
	following:	a poncy maicated the					
	ionowing.						
	PURPOSE						
	* To protect wou						
	* To prevent infection.						
	•	ection and spread of					
	infection.						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA						(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155295	B. WIN			05/04/2	011
NAME OF E	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				1	FREEMAN ST		
CLINTON	N HOUSE HEALTH	AND REHAB CENTER		FRANK	(FORT, IN46041		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	* To promote healing.						
	PROCEDURE6. Remove soiled dressing and discard						
		led dressing and discard					
	in plastic bag.	over in plactic bas					
	1 1	oves in plastic bag.					
		pair of disposable					
	gloves.						
	The handweeking	g audit was provided by					
		sultant on 5/03/11 at 3:55					
	_						
	_	at audit indicated the					
	following:						
	" Soan hands I	Use friction to clean					
	1 ^	sing one verse of happy					
	birthday.	ang one verse of nappy					
	ontiliday.						
	Ouiz: When sh	nould you wash your					
	hands?	iodid you wasii youi					
		all direct contact with					
		ng contact with skin or					
	body fluids.	-5 Johnson Willi Digili Ol					
	After glove use	"					
	11101 510 10 450						
	2. On 5/03/11 fro	om 9:10 a.m. to 9:40					
		's right gluteal dressing					
	change was observed. After obtaining her supplies, including a debridement kit, Physical Therapist (PT) #3 was observed						
		less than 10 seconds.					
		e debridement kit on the					
		e donned a pair of gloves					
		soiled dressing, The					
					<u> </u>		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					NSTRUCTION 00	COMPI	
11.12.12.11.	or continuenton	155295	1 ' '	LDING	<del></del>	05/04/2	
		100200	B. WIN	_	DDDECC CITY CTATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE FREEMAN ST		
CLINTO	N HOUSE HEALTH	AND REHAB CENTER		1	FORT, IN46041		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		vas observed wet with a					
		drainage on the dressing.					
		e during an interview, PT					
		odor now present was not					
	1	ay, and she indicated the					
	_	ly from the necrotic					
		same gloves, PT #3 then					
	1 ^ _	ce her gloved finger					
	1 ^	rea as she checked the					
		ng. The surrounding area					
	_	was observed to be bright					
		er removing her gloves					
		ew pair, PT #3 debrided a					
		e amount of dark yellow					
	I -	nce from the wound.					
		cated she had completed					
		dement, she placed the					
	1	I tweezers on the paper					
		ray of the debridement					
		ansed the open area with					
		hands and a piece of					
	-	times. Next, as she					
		sure the open area, she					
	I -	nt hand glove, retrieved a					
	1	cket, and then, donned a					
	_	right hand. Next, she					
	1	en area with a paper					
		and Q-tip. With a second					
		me gloves, she swabbed					
	1 ^	area with Sanytl					
	· · · · · · · · · · · · · · · · · · ·	e debridement tweezers to					
	1 -	ea, and covered it with					
	1	. After she removed her					
	gloves, she used	the retrieved pen to mark					

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cility ID: 000192

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155295			ULTIPLE CO LDING	onstruction 00	(X3) DATE S COMPL 05/04/2	ETED	
		100290	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	05/04/2	U11
NAME OF I	PROVIDER OR SUPPLIER			1	FREEMAN ST		
CLINTON	N HOUSE HEALTH	AND REHAB CENTER	FRANKFORT, IN46041				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
	the date and initials on the dressing. After						
	cleaning up the area, she was observed to handwash for 12 seconds. At this same time during an interview, PT #3 indicated one should handwash for the length of						
	time it took to re-	· ·					
		25 a.m. during an					
	interview, PT #3 Resident #I's ski	n surrounding the open					
		she indicated the dressing					
		be changed more often.					
		e could not be sure if the					
	_	wet just from the wound					
	drainage or due t incontinence.	to the resident's					
	meonumence.						
	Resident #J's rec	ord was reviewed on					
	-	.m. The resident's					
	_	ed, but were not limited					
	to, sacral decub t	ilcei.					
	The physician or	der, dated 4/13/11, was					
	wound care clari	fication to continue					
		porin powder on wound					
		order gauze. Physical					
	therapy was to do wound care on Monday through Friday, and nursing was to do it						
	on Saturday and Sunday.						
	and any and and and any						
		e score, dated 4/13/11,					
		tal score of 12 or less					
	represented a hig	gn fisk.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155295		A. BUII	LDING	NSTRUCTION  00	(X3) DATE COMPI 05/04/2	LETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE FREEMAN ST FORT, IN46041	<u> </u>	
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	DATE
	The "PRESSUR" EVALUATION I following:	E ULCER RECORD" indicated the					
	measured 1 cm is and 0.1 cm depth drainage and gradrainage. On 4/25/11 the recentimeters (cm) by 0.1 cm depth the 9 o'clock, 12 locations. Serous indicated with percentimeters during the serous drains slough with important tunneling inform.  The "PRESSURE 5/02/11, indicated with and the serous drains are the serous drains th	tage II right gluteal area in length by 1.1 cm. width in with serosanguineous inulating with light.  Ight buttock measured 3 length by 2.5 cm width with 1 cm of tunneling at o'clock, and 3 o'clock is with 100% slough was por progress noted.  Ight buttock measured 3 in width by 1.6 cm depth inage indicated and 55% rovement noted. No ation was indicated.  E ULCER LOG," dated in depth in the control of the cont					
	12, 1.5 cm at 3 o'clock, 1.5 cm at 6 o'clock, and 1.5 cm at 9 o'clock.						
	3. On 5/01/11 at 10:55 p.m., Resident #L's personal care was observed. As CNA #4 removed the resident's brief, she						
	indicated he had urine. Also, the and sheet for rep	been incontinent of resident's bottom sheet ositioning were also					
		m urine. During his e resident's left buttock					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155295		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION  00	(X3) DATE S COMPL 05/04/2	ETED	
NAME OF	PROVIDER OR SUPPLIEI	<b>"</b> }			ADDRESS, CITY, STATE, ZIP CODE	•	
CLINTO	N HOUSE HEALTH	AND REHAB CENTER			FREEMAN ST FORT, IN46041		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	3 cm. sized obloshis care was consonly applied, and repositioned in Font 5/01/11 at 11 interview with L. Granulex had be buttocks, and shinsurance would indicated barrier applied, and she on the barrier cronot applied by the care.  On 5/02/11 at 10 interview, LPN is treatment for his given last night indicated she would indicated she would indicated she would interview. The side of the physician dustreatment orderer resident's insurant of the physician dustreatment orderer resident's insurant on 5/02/11 from 3: #L's personal care with the physician dustreatment orderer in the during an interview with a whole of the physician dustreatment orderer resident had been in always incontinent observed with a whole of the physician dustreatment orderer in the physician dustreatment orderer in the physician dustreatment orderer resident's insurant orderer resident's insurant orderer in the physician dustreatment orderer resident's insurant orderer resident had been in always incontinent observed with a whole of the physician dustreatment orderer resident had been in always incontinent observed with a whole of the physician dustreatment orderer resident had been in always incontinent observed with a whole of the physician dustreatment orderer resident had been in always incontinent observed with a whole of the physician dustreatment orderer resident had been in always incontinent observed with a whole of the physician dustreatment orderer resident had been in always incontinent observed with a whole of the physician dustreatment orderer resident had been in always incontinent observed with a whole of the physician dustreatment orderer resident had been in always incontinent observed with a whole of the physician dustreatment orderer resident had been in always incontinent observed with a whole of the physician dustreatment orderer resident had been in always incontinent observed with a whole of the physician dustreatment orderer resident had been in always incontinent orderer resident had been in always incontinent ordere	:15 p.m. during an PN #5, she indicated en ordered for his e did not have any as his not pay for it. She cream should had been would go back in and put eam due to the cream was he CNA during personal  2:10 a.m. during an #1 indicated Resident #L's buttock had not been as scheduled. She buld have to check with e to she thought the d was not covered by the					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DINC	00	COMPL	LETED
		155295	B. WIN			05/04/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			FREEMAN ST		
CLINTO	N HOUSE HEALTH	AND REHAB CENTER		1	FORT, IN46041		
CLINTOI	· · · · · · · · · · · · · · · · · · ·	AND REHAB CENTER		FIXAINI			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	<b>.</b>	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	did not want to wash his cream off.						
		d was reviewed on 5/02/11 at					
	_	ident's diagnoses included, but					
		dementia, Insulin dependent					
		nd depression. The resident					
		assistance of 1 to 2 persons for					
		ving and was incontinent of					
	bowel and bladder.						
	The faxed transmiss	sion on 4/29/11 was a request					
		ore if (sic) worsens" for a					
		(in a circle) (bilateral)					
		sician order was Granulex					
	daily for 14 days.	Siciali order was Grandiex					
	duity for 11 days.						
	The faxed transmiss	sion on 4/30/11 was a request					
		nent as Granulex was not					
		rance. The physician had					
	1	on concerning what treatment					
		The answer was returned on					
		A & D ointment (barrier cream)					
	every shift for 10 da						
	The physician order	r, dated 5/03/11, was to					
	discontinue the A &	D ointment and to start					
	Desitin (skin protec	tant) to reddened area on					
	buttocks 1 time a da	ay for 14 days.					
		URE SKIN CONDITION					
	REPORT" indicated	the following:					
	On 4/19/11, the "buttocks gluteal fold" and "back						
	of scrotum" with the area measuring 2.5 cm (centimeter) length by 1 cm width by 0.1 cm depth						
	The condition was indicated as "excoriation" and "denuded" with a pink/beefy red wound bed.						
		-					
		k/beefy red wound bed gth by 1 cm width and 0.1 cm					
	· ·	gui by 1 cm widin and 0.1 cm					
	depth.						

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Event ID:

P42B12

Facility ID:

000192

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		155295	B. WIN	j		05/04/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
OL INITON	LUQUOE LIEALTIL	AND DELIAD CENTED			FREEMAN ST		
CLINTON	N HOUSE HEALTH /	AND REHAB CENTER		FRANK	FORT, IN46041		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		c/beefy red wound bed th by 1 cm width with the skin					
	intact.						
		ciency was cited on					
		ility failed to implement					
	a systemic plan o	of correction to prevent					
	recurrence.						
	This federal defic	ciency relates to					
	Complaint #IN00089874.						
	3.1-40(a)(2)						
F0425 SS=D	residents, or obtain described in §483. facility may permit administer drugs if	rovide routine and and biologicals to its n them under an agreement .75(h) of this part. The unlicensed personnel to f State law permits, but only supervision of a licensed					
	services (including accurate acquiring	vide pharmaceutical g procedures that assure the g, receiving, dispensing, and Il drugs and biologicals) to each resident.					
	of a licensed phare	mploy or obtain the services macist who provides aspects of the provision of s in the facility.					
	interview, the fac medications were administration fo	review, observation and cility failed to ensure available for 2 of 10 residents dication availability in a	F0	425	F425 It is the practice of this facility to employ or obtain the services of a licensed pharm who provides consultation of pharmacy services in the faction of the faction	e acist ility.	05/25/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155295	B. WIN			05/04/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	t			FREEMAN ST		
CLINTO	N HOUSE HEALTH	AND REHAB CENTER		1	FORT, IN46041		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)	+	TAG			DATE
	sample of 10.				assessed to ensure there ha		
	(Resident #'s I ar	nd L)			been no adverse effects due the alleged deficient practice		
					Residents who received	. 11.)	
	Findings include	:			medications through the		
					contracted pharmacy have the	ne	
	1. The record fo	r Recident I was			potential to be affected. A		
					reconciliation of current in ho	use	
	reviewed on 5/2/	11 at 2.48 p.m.			residents physician's orders		
					medication availability has be	een	
		ory test indicated the			completed. Medications or		
	resident was pos	itive for Clostridium			treatments not available, if and have been ordered and the	ny,	
	Difficile Toxin (	C-Diff).			physician has been notified.		
					Administrator has made conf	act	
	A physician ord	er dated 4/5/11 indicated			with contracted pharmacy,		
		comycin (antibiotic) 125			requesting the pharmacy ser	nd a	
		times daily for 7 days,			3 day supply of any medicati	on or	
	1	•			treatment not covered by		
	1	for 7 days, then once			insurance, allowing time to		
	daily for 7 days.				contact the doctor for new or		
					if needed. III.) Nursing sta has been re-educated on fac		
	The April 2011 N	Medication			procedure for ordering	illty	
	Administration F	Record (MAR) indicated			medications/ treatments and		
	the Vancomycin	was not given on			directed to contact the Direct	or of	
	1	back of the MAR			Nursing or Administrator if		
		4/11 the Vancomycin was			medications/treatments are r		
		4/25/11 the MAR			available in a timely manner.		
					Director of Nursing or design	iee	
		ncomycin was not in the			will review medication and treatment administration reco	orde	
		g Kit and the pharmacy			daily for 4 weeks, then 3 time		
	was notified. There was not explanation why the Vancomycin was not given on 4/27/11.				week for 4 weeks, then week		
					4 weeks to ensure	,	
					medications/treatments are		
					available for administration a		
	A physician order dated 4/27/11 indicated				ordered. Non-compliance wi	ill be	
	an order for the Vancomycin to be given				addressed through 1:1	nivo	
		to replace the missed			re-education and/or progress		
	1	-			disciplinary actions as indica  Results will be reviewed in C		
	doses due to the	supply had expired.			Lizeanie min ne reviewed in C	AXA	

DENTIFICATION HOUSE RECEIVED   DESCRIPTION	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
NAME-OF PROVIDER OR SUPPLIER  CLINTON HOUSE HEALTH AND REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES PREETX TAG  REGULATORY OR ISC IDENTIFYING INFORMATION) TAG  REGULATORY OR ISC IDENTIFYING INFORMATION During an interview with the Director of Nursing on 53/11 at 9:40 a.m., she indicated 3 doses of the Vancomycin were not given.  2. On 5/01/11 at 10:55 p.m. and on 5.02/11 at 3:55 p.m., Resident #1.'S personal care was observed. During these care observations, the resident's left buttock was observed with a 2 centimeter (cm) by 3 cm. sized oblonged dark red area.  On 5/01/11 at 11:15 p.m. during an interview with LIN #5, she indicated barrier cream was being used presently.  On 5/02/11 at 10:10 a.m. during an interview, I.PN #1 indicated Resident #1.'S treatment for his buttock had not been given last night (5/01/11) as scheduled. She indicated she would have to check	AND PLAN	OF CORRECTION		A. BUI	LDING	00		
NAME OF PROVIDER OR SUPPLIER  CLINTON HOUSE HEALTH AND REHAB CENTER  REGULATORY OR ISC IDENTIFYING REFORMATION;  During an interview with the Director of Nursing on 5/3/11 at 9:40 a.m., she indicated 3 doses of the Vancomycin were not given.  Douring an interview with the Director of Nursing on 5/3/11 at 9:40 a.m., she indicated 3 doses of the Vancomycin were not given.  Douring an interview with a 2 centimeter (cm) by 3 cm. sized oblonged dark red area.  On 5/01/11 at 11:15 p.m. during an interview with LPN #5, she indicated Granulex had been ordered for his buttocks. She indicated barrier cream was being used presently.  On 5/02/11 at 10:10 a.m. during an interview, LPN #1 indicated Barrier cream was being used presently.  Sough FREEMAN ST FRANKFORT, INA8041  Director of PREFIX TAG  Director of Nursing or designee will review medications free			133293	B. WIN		PRESIDENCE CONTROL CON	03/04/2	011
CLINTON HOUSE HEALTH AND REHAB CENTER   FRANKFORT, IN46041	NAME OF F	PROVIDER OR SUPPLIER			1			
SUMMARY STATEMENT OF DEFICIENCY ENTER THE PERCEPS IN FULL. TAG   PREFIX   REGULATORY OR LSC IDENTIFYING INFORMATION   TAG	CLINTON	N HOUSE HEALTH	AND REHAB CENTER		1			
PREFIX REGULATORY OR LSC IDENTIFYING INTORMATION)  During an interview with the Director of Nursing on 5/3/11 at 9:40 a.m., she indicated 3 doses of the Vancomycin were not given.  2. On 5/01/11 at 10:55 p.m. and on 5.02/11 at 3:55 p.m., Resident #L's personal care was observed. During these care observations, the resident's left buttock was observed with a 2 centimeter (cm) by 3 cm. sized oblonged dark red area.  On 5/01/11 at 11:15 p.m. during an interview with LPN #5, she indicated Granulex had been ordered for his buttocks. She indicated she did not have any Granulex due to his insurance would not pay for it. She indicated Basic death #L's treatment for his buttock had not been given last night (5/01/11) as scheduled. She indicated she would have to check  PREFIX 1AG  PREFIX 1AG  COMPLETION 1AG  COM					L			(V5)
During an interview with the Director of Nursing on 5/3/11 at 9:40 a.m., she indicated 3 doses of the Vancomycin were not given.  2. On 5/01/11 at 10:55 p.m. and on 5.02/11 at 3:55 p.m., Resident #L's personal care was observed. During these care observations, the resident's left buttock was observed with a 2 centimeter (cm) by 3 cm. sized oblonged dark red area.  On 5/01/11 at 11:15 p.m. during an interview with LPN #5, she indicated Bardade Granulex had been ordered for his buttocks. She indicated she did not have any Granulex due to his insurance would not pay for it. She indicated Bardade HL's treatment for his buttock had not been given last night (5/01/11) as scheduled. She indicated she would have to check  Tag Construction of the APPROPARTA BERGADE TO THE APPROPARTA AND THE BERCADE TO THE BERCADE TO THE APPROPARTA AND THE BERCADE TO THE APPROPARTA AND THE BERCADE TO THE APPROPARTA AND THE BURCHEST AND THE APPROPARTA AND THE APPROPARTA AND THE APPROPARTA AND THE BURCHEST AND THE APPROPARTA AND THE BURCHEST AND THE BURC	l					(EACH CORRECTIVE ACTION SHOULD BE		
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interview, LPN #1 indicated Resident #L's treatment for his buttock had not been given last night (5/01/11) as scheduled. She indicated she would have to check		During an intervinal Nursing on 5/3/1 indicated 3 doses not given.  2. On 5/01/11 at 5.02/11 at 3:55 p personal care was care observations buttock was obsection by 3 cm. siziarea.  On 5/01/11 at 11 interview with Liferanulex had been buttocks. She imany Granulex due not pay for it. She was being used processed in the sizing of the sizin	iew with the Director of 1 at 9:40 a.m., she sof the Vancomycin were sof the Vancomycin were be soften and on a.m., Resident #L's sobserved. During these soften are the resident's left are doblonged dark red are doblonged dark red are to his insurance would be indicated barrier cream presently.			meeting monthly for 3 month and then quarterly with a subsequent plan developed implemented as indicated.  ADDENDUM: The Director of Nursing or designee will review medication and treatment administration records daily weeks, then 3 times a week weeks, then weekly for 4 we then monthly times 3 months ensure medications/treatment are available for administration.	and  of ew  for 4 for 4 eks, s, to onts	
treatment for his buttock had not been given last night (5/01/11) as scheduled.  She indicated she would have to check			C					
given last night (5/01/11) as scheduled. She indicated she would have to check		l '						
She indicated she would have to check								
with the physician due to she thought the		~ ~ ~ ~						

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		BUILDING 00			COMPLETED	
		155295 B. WIN				05/04/2011		
		l .	D. ((1)		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	₹			FREEMAN ST			
CLINTON HOUSE HEALTH AND REHAB CENTER				FRANKFORT, IN46041				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CON CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG			DATE	
	treatment ordered was not covered by the							
	resident's insura	nce.						
	resident s insurance.							
	Resident #L's record was reviewed on 5/02/11 at							
	12:15 p.m. The resident's diagnoses included, but							
	were not limited to,	dementia, Insulin dependent						
	diabetic mellitus, ar	nd depression.						
	•							
	The faxed transmission on 4/29/11 was a request							
	for a treatment "before if (sic) worsens" for a							
		(in a circle) (bilateral)						
	buttocks." The physician order was Granulex							
	daily for 14 days.							
	The faxed transmission on 4/30/11 was a request							
	for a different treatment as Granulex was not							
	covered by his insurance. The physician had requested information concerning what treatment would be covered. The answer was returned on 5/02/11 requesting A & D ointment (barrier cream) every shift for 10 days.							
	The physician order, dated 5/03/11, was to discontinue the A & D ointment and to start Desitin (skin protectant) to reddened area on buttocks 1 time a day for 14 days.							
	The 4/2011 medication/treatment record indicated							
		een given on 4/29 or 4/30/11 as						
	ordered. No reason was indicated on this record.							
	This federal defi	ciency was cited on						
		cility failed to implement						
		of correction to prevent						
	recurrence.							
	3.1-25(a)							

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
AND I LAN OF CORRECTION		155295	A. BUILDING B. WING		05/04/2011	
NAME OF E	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE		
		AND REHAB CENTER		(FORT, IN46041		
(X4) ID PREFIX		(FACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIV		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE		